		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0021832

Facility Name: Arthur Merkle-Clara Knipprath Nursing Home

Address: 1190 East 2900 North Road (Number) Clifton (City) 60927 (Zip Code)

County: Iroquois

Telephone Number: (815) 694-2306 **Fax #** (815) 694-2818

IDPA ID Number: 362841358001

Date of Initial License for Current Owners: 10/15/75

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL		
	x	Charitable Corp.		Individual		State	
		Trust		Partnership		County	
IRS Exemption Code	501(c)(3)			Corporation		Other	
				"Sub-S" Corp.			
				Limited Liability Co.			
				Trust			
				Other			

In the event there are further questions about this report, please contact:
Name: Brother Damien **Telephone Number:** (815) 694-2306

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/2002 to 12/31/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Brother Damien, OSF
(Title) Executive Director

Paid Preparer
(Signed) See Accountant's Report (Date)
(Print Name and Title) Mark L Smith, President
(Firm Name & Address) Smith Koelling Dykstra & Ohm, PC, 1605 N Convent, Bourbonnais, IL
(Telephone) (815) 937-1997 Fax # (815)935-0360

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	99	Skilled (SNF)	99	36,135	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	99	TOTALS	99	36,135	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	323	229		552	8
9	SNF/PED					9
10	ICF	10,167	14,944		25,111	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,490	15,173		25,663	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.02%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10 / 6 / 75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [x]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/2002 Fiscal Year: 12/31/2002

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Hoı # 0021832 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	246,395	23,254	12,665	282,314		282,314		282,314			1
2	Food Purchase		148,714		148,714	(21,080)	127,634	(11,699)	115,935			2
3	Housekeeping	64,706	359	11,075	76,140		76,140	(11,139)	65,001			3
4	Laundry	25,990	4,579	7,425	37,994		37,994		37,994			4
5	Heat and Other Utilities			123,451	123,451	(2,261)	121,190	(22,719)	98,471			5
6	Maintenance	71,020	1,808	9,433	82,261	(75)	82,186	(15,136)	67,050			6
7	Other (specify):*			3,114	3,114		3,114		3,114			7
8	**TOTAL General Services**	408,111	178,714	167,163	753,988	(23,416)	730,572	(60,693)	669,879			8
	B. Health Care and Programs											
9	Medical Director			4,100	4,100		4,100		4,100			9
10	Nursing and Medical Records	851,008	81,873	4,982	937,863		937,863	(13,500)	924,363			10
10a	Therapy	14,549		429	14,978		14,978		14,978			10a
11	Activities	59,415	11,291	8,024	78,730		78,730	(3,824)	74,906			11
12	Social Services	20,104			20,104		20,104		20,104			12
13	Nurse Aide Training											13
14	Program Transportation			683	683		683		683			14
15	Other (specify):*			719	719		719	(719)				15
16	**TOTAL Health Care and Programs**	945,076	93,164	18,937	1,057,177		1,057,177	(18,043)	1,039,134			16
	C. General Administration											
17	Administrative	75,000			75,000	5,734	80,734	(20,734)	60,000			17
18	Directors Fees											18
19	Professional Services			18,656	18,656		18,656		18,656			19
20	Dues, Fees, Subscriptions & Promotions			4,158	4,158		4,158		4,158			20
21	Clerical & General Office Expenses	83,648	2,495	7,634	93,777		93,777	(118)	93,659			21
22	Employee Benefits & Payroll Taxes			337,182	337,182	21,080	358,262	(4,960)	353,302			22
23	Inservice Training & Education			1,627	1,627		1,627		1,627			23
24	Travel and Seminar			13	13		13		13			24
25	Other Admin. Staff Transportation			1,159	1,159		1,159		1,159			25
26	Insurance-Prop.Liab.Malpractice			23,972	23,972	(175)	23,797	(1,978)	21,819			26
27	Other (specify):*											27
28	**TOTAL General Administration**	158,648	2,495	394,401	555,544	26,639	582,183	(27,790)	554,393			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,511,835	274,373	580,501	2,366,709	3,223	2,369,932	(106,526)	2,263,406			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home #0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			210,071	210,071	(3,223)	206,848	(77,070)	129,778			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			210,071	210,071	(3,223)	206,848	(77,070)	129,778			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops		24	17,797	17,821		17,821	(17,821)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,203	54,203		54,203		54,203			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		24	72,000	72,024		72,024	(17,821)	54,203			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,511,835	274,397	862,572	2,648,804		2,648,804	(201,417)	2,447,387			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Arthur Merkle-Clara Knipprath Nursing Home
ID# 0021832
Report Period 1/1/02 to 12/31/02
Schedule V Attachment - Reclassification

Food Purchase	Line 2, Col 5	($21,080)
Employee Benefits and Payroll Taxes (To reclassify employee meals)	Line 22, Col 5	21,080
Heat & Other Utilities	Line 5, Col 5	(2,261)
Maintenance	Line 6, Col 5	(75)
Insurance, Property and Liability	Line 26, Col 5	(175)
Depreciation	Line 30, Col 5	(3,223)
Administrative (To reclassify administrative costs for Brothers' residence)	Line 17, Col 5	5,734
Total Reclassification	Line 45, Col 5	$0

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VI. ADJUSTMENT DETAIL A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(6,113)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,824)	11		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	8,869	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(200,349)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (201,417)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (201,417)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Arthur Merkle-Clara Knipprath Nursing Home

ID# 0021832

Report Period Beginning: 1/1/2002

Ending: 12/31/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Independent Living Unit -Maintenance Wages	$ (10,000)	6	1
2	Independent Living Unit Wages	(13,500)	10	2
3	Independent Living Unit Wages - Administration	(15,000)	17	3
4	Independent Living Unit Employee Benefits	(4,960)	22	4
5	Independent Living Unit Wages	(11,139)	3	5
6	Independent Living Unit Insurance	(1,978)	26	6
7	Independent Living Unit Depreciation	(85,939)	30	7
8	Independent Living Unit Utilities	(22,719)	5	8
9	Independent Living Unit-Supplies	(118)	21	9
10	Independent Living Unit Maintenance & Other	(5,136)	6	10
11	Independent Living Unit Food Cost	(5,586)	2	11
12	Administration Cost for Brothers' Residence	(5,734)	17	12
13	Adjust Barber & Beauty due to income received	(17,821)	40	13
14	Adj Sundried due to income received	(719)	15	14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(200,349)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(11,699)	0	0	0	0	0	0	0	0	0	0	(11,699)	2
3	Housekeeping	(11,139)	0	0	0	0	0	0	0	0	0	0	(11,139)	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(22,719)	0	0	0	0	0	0	0	0	0	0	(22,719)	5
6	Maintenance	(15,136)	0	0	0	0	0	0	0	0	0	0	(15,136)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(60,693)	0	0	0	0	0	0	0	0	0	0	(60,693)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(13,500)	0	0	0	0	0	0	0	0	0	0	(13,500)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	(3,824)	0	0	0	0	0	0	0	0	0	0	(3,824)	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(719)	0	0	0	0	0	0	0	0	0	0	(719)	15
16	**TOTAL Health Care and Programs**	(18,043)	0	0	0	0	0	0	0	0	0	0	(18,043)	16
	C. General Administration													
17	Administrative	(20,734)	0	0	0	0	0	0	0	0	0	0	(20,734)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(118)	0	0	0	0	0	0	0	0	0	0	(118)	21
22	Employee Benefits & Payroll Taxes	(4,960)	0	0	0	0	0	0	0	0	0	0	(4,960)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	(1,978)	0	0	0	0	0	0	0	0	0	0	(1,978)	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(27,790)	0	0	0	0	0	0	0	0	0	0	(27,790)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(106,526)	0	0	0	0	0	0	0	0	0	0	(106,526)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home **#** 0021832 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(77,070)	0	0	0	0	0	0	0	0	0	0	(77,070)	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(77,070)	0	0	0	0	0	0	0	0	0	0	(77,070)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(17,821)	0	0	0	0	0	0	0	0	0	0	(17,821)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(17,821)	0	0	0	0	0	0	0	0	0	0	(17,821)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(201,417)	0	0	0	0	0	0	0	0	0	0	(201,417)	45

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Franciscan Missionary Brothers of the Sacred Heart of Jesus	100%	N/A				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing H(# 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
						Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Hours	Percent	Description	Amount	Schedule V. Line & Column Reference	
1	Bro. Damien Dabraekeleer	Executive Director	Administrator	0.00	0	46	100.00	Stipend to	$ 75,000	Col 4,Ln17	1
2	Bro. William Farrelly	Director	Nursing	0.00	0	44	100.00	Religious	67,500	Col 4,Ln10	2
3	Bro. Joseph Ruscha	Director	Maintenance	0.00	0	44	100.00	Order	49,996	Col 4,Ln 6	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 192,496		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 2/31/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Ho # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	None						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	None											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	None											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** _____ **Line #** _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	Tax Exempt	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$		2
3. Under or (over) accrual (line 2 minus line 1).	$		3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$		4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$		7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1997		8
1998		9
1999		10
2000		11
2001		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Arthur Merkle-Clara Knipprath Nursing Home COUNTY Iroquois

FACILITY IDPH LICENSE NUMBER 0021832

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 53,919 B. General Construction Type: Exterior Brick Frame Masonry Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Countryside Villas, 15 unit Independent Living Units - 17005 square feet

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	SNF	1,730,560	1975	$ 24,225	1
2	Farm/ILU	995,072	1975	32,775	2
3	TOTALS	2,725,632		$ 57,000	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	99		1975	1975	$ 773,471	$ 16,432	33	$ 16,429	$ (3)	$ 591,830	4
5			1975	1975	432,948	8,539	25	10,790	2,251	383,577	5
6											6
7											7
8											8
	Improvement Type**										
9	Fixed Equipment			1981	924		5			924	9
10				1982	656		15			656	10
11				1983	5,462	253	17	253		5,116	11
12				1984	16,618	588	15	587	(1)	15,737	12
13				1985	6,098	191	15	191		4,571	13
14				1986	2,400		10			2,400	14
15				1987	6,773		25			6,773	15
16				1988	650	45	15	45		628	16
17				1979	2,032		5			2,032	17
18				1980	14,012		15			14,012	18
19				1989	9,327	388	20	388		5,996	19
20				1990	1,276		10			1,276	20
21				1991	25,219	1,231	20	1,231		14,755	21
22				1992	6,594	440	15	436	(4)	4,616	22
23				1993	2,825	282	10	283	1	2,684	23
24				1995	97,366	4,109	25	4,108	(1)	30,817	24
25	Fire Supression-Kitchen			1996	2,115	106	20	105	(1)	687	25
26	Nurses Station Impr			1996	5,395	360	15	359	(1)	2,338	26
27	Verticla Blinds-Arthur			1996	350	35	10	35		227	27
28	Heat pump compressor			1996	1,890	189	10	189		1,229	28
29	Therapy Room Cubicle			1996	321	32	10	33	1	209	29
30	Kitchen Heat Pump			1996	1,679	168	10	167	(1)	1,091	30
31	2 Water Heaters			1996	4,158	277	15	278	1	1,802	31
32	Call Light System			1996	1,348	90	15	89	(1)	584	32
33	Room Heaters			1996	3,603	360	10	362	2	2,342	33
34	Pump/Generator Impr			1997	2,540	254	5	254		2,540	34
35	Fire Alarm Impr			1997	1,105	110	5	111	1	1,105	35
36	Fire Safety Code Impr			1997	5,844	390	15	389	(1)	2,143	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Procare Nurse Call System	1997	$ 36,033	$ 2,402	15	$ 2,401	$ (1)	$ 13,212	37
38	Garbage Disposal	1998	1,142	76	15	77	1	343	38
39	Heat Pump	1998	2,853	285	10	286	1	1,284	39
40	Fire Door	1998	200	10	20	10		45	40
41									41
42	Room Heat/Cool Unit	1998	3,632	363	10	363		1,634	42
43	Generator	1998	141,059	7,053	20	7,054	1	31,738	43
44	Cubicle Curtains	1998	5,250	525	10	525		2,363	44
45	Register Covers	1999	1,056	106	10	106		370	45
46	Walk-in Freezer/Cooler	1999	20,126	805	25	805		2,818	46
47	Water Heater Booster	1999	1,131	113	10	113		396	47
48	Above Ground Tank	1999	1,495	149	10	150	1	523	48
49									49
50	Air/Heat Unit	1999	1,057	211	5	212	1	740	50
51	Air Return Extension	2000	1,532	102	15	102		255	51
52	SS Garbage Disposal	2000	527	26	20	27	1	66	52
53	(2) Air /Heat Units	2000	1,950	390	5	390		975	53
54	Resident Security System	2001	4,830	483	10	484	1	725	54
55	Sewage Component Impr	2001	4,549	303	15	304	1	455	55
56	Disposal	2001	549	55	10	55		82	56
57	Dehumidifier	2001	1,050	105	10	106	1	158	57
58	Chapel Heating/Cooling	2001	19,000	2,216	10	2,217	1	2,850	58
59	Natural Gas Hot Water Conversion	2002	29,705	990	15	990		990	59
60	Resident Hall Water Coolers	2002	1,657	83	10	83		83	60
61	Sewer Lagoon Impr	2002	6,824	341	10	341		341	61
62	Time Clock	2002	395	20	10	20		20	62
63									63
64	Land Improvements	1975	194,467	2,899	25	2,899		158,223	64
65		1979	8,614		20			8,614	65
66		1982	42,700	168	11	310	142	42,700	66
67		1983	1,999	100	20	100		1,949	67
68		1984	3,405	170	20	170		3,148	68
69		1985	860		12			860	69
70	TOTAL (lines 4 thru 69)		$ 1,974,646	$ 55,418		$ 57,812	$ 2,394	$ 1,382,657	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,974,646	$ 55,418		$ 57,812	$ 2,394	$ 1,382,657	1
2		1986	6,156		15			6,156	2
3		1980	762		20			762	3
4		1992	6,346	318	20	318		3,332	4
5		1993	3,640		5			3,640	5
6		1995	6,753	413	15	413		3,096	6
7	Drive Pavement	1997	8,900	594	15	594		3,263	7
8	Well	1998	7,339	367	20	367		1,651	8
9	Sewer Impr	1999	13,399	1,340	10	1,340		4,690	9
10	Drive Sealing	2000	8,945	1,789	5	1,789		4,473	10
11	Landscaping	2002	4,211	140	15	140		140	11
12	Drive Widening	2002	32,150	1,608	10	1,608		1,608	12
13									13
14	Buildings	1980	4,422		20			4,422	14
15		1981	1,738		10			1,738	15
16		1982	1,106	45	25	45		907	16
17		1984	130,023	19	20	6,500	6,481	117,026	17
18		1985	598		15			598	18
19		1986	640,838	20,158	33	20,158		347,130	19
20		1987	37,528	1,295	15	1,295		37,484	20
21		1988	13,228	882	15	882		12,787	21
22		1989	10,488	100	15	98	(2)	10,339	22
23		1990	2,096		10			2,096	23
24		1991	35,542	1,815	20	1,815		20,872	24
25		1992	(34,187)	(810)	40	(810)		(8,505)	25
26		1993	475	48	10	45	(3)	451	26
27	Floor Tile Nurse Station	1996	2,050	137	15	136	(1)	888	27
28	Floor Tile Clara Wing	1996	778	52	15	51	(1)	337	28
29	Floor Tile, Main, Kitchen	1997	14,739	2,106	7	2,105	(1)	11,581	29
30	Hallway Impr	1997	3,870	387	5	387		3,870	30
31	Roof Improvements	1997	13,828	922	15	922		5,071	31
32	Floor Tile Arthur Wing	1998	6,475	647	10	649	2	2,914	32
33	DR Vinyl Flooring	1999	4,420	884	5	884		3,094	33
34	TOTAL (lines 1 thru 33)		$ 2,963,302	$ 90,674		$ 99,543	$ 8,869	$ 1,990,568	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,963,302	$ 90,674		$ 99,543	$ 8,869	$ 1,990,568	1
2	Interior Corridor Doors	2000	2,415	161	10	161		403	2
3	Chapel Roof (Partial)	2001	3,099	207	15	207		310	3
4	Kitchen Doors	2001	1,031	103	10	103		155	4
5	New Roof	2002	32,319	808	20	808		808	5
6	Floor Tile	2002	2,919	97	15	97		97	6
7	Maintenance Shed	2002	7,010	140	25	140		140	7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,012,095	$ 92,190		$ 101,059	$ 8,869	$ 1,992,481	34

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Arthur Merkle-Clara Knipprath Nursing Home
ID# 0021832
Report Period Beginning 1/1/02 to 12/31/02
Attachment to Schedule XI, Page 12B, Line 25

The Nursing Home received an adjustment on building improvements constructed in 1982 due to construction problems relating to leakage in the chapel roof. This amount is reflected as a 1992 line item and adjusted prospectively.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 221,860	$ 22,076	$ 22,076	$	Various	$ 65,776	71
72	Current Year Purchases	25,473	1,732	1,732		Various	1,732	72
73	Fully Depreciated Assets	206,543					206,543	73
74								74
75	TOTALS	$ 453,876	$ 23,808	$ 23,808	$		$ 274,051	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	1996 Ford Eldorado Transit	1996	$ 38,099	$ 3,810	$ 3,810	$	10	$ 24,764	76
77	Facility Business	1996 Mercury Sable	1996	15,878				4	15,878	77
78	Patient Transport	1993 Mercury Villager	1992	18,387				5	18,387	78
79	Maintenance Truck	1997 GMC Truck	2002	14,580	1,041	1,041		7	1,041	79
80	TOTALS			$ 86,944	$ 4,851	$ 4,851	$		$ 60,070	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,609,915	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 120,849	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 129,718	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,869	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 2,326,602	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	Brothers Residence	$ 94,816	$ 2,370	$ 65,184	86
87	Brothers Residence Equipment	20,342	913	12,280	87
88	Apartment Complex Bldg	1,786,199	52,214	558,817	88
89	Apartment Complex Equipment	727,451	32,659	365,346	89
90	Apartment Complex Land Impr	21,325	1,066	11,728	90
91	TOTALS	$ 2,650,133	$ 89,222	$ 1,013,355	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

All new nurses aids are required to have completed the proper training.

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 21,356	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 26,000)	216,282		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	2,922,303		5
6	Prepaid Insurance	20,925		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Accrued Interest	23,982		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 3,204,848	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	175,453		12
13	Land	425,208		13
14	Buildings, at Historical Cost	3,593,335		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	2,242,370		16
17	Accumulated Depreciation (book methods)	(3,346,527)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 3,089,839	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 6,294,687	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 96,308	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	5,228		30
31	Accrued Taxes Payable (excluding real estate taxes)	2,089		31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Apartment Rental Deposit	35,515		36
37	Accrued Pension Payable	16,880		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 156,020	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 156,020	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 6,138,667	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 6,294,687	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 6,089,477	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 6,089,477	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	49,190	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 49,190	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 6,138,667	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,026,798	1
2	Discounts and Allowances for all Levels	(705,414)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,321,384	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	6,273	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 6,273	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	25,270	13
14	Non-Patient Meals	20,288	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 45,558	23
	D. Non-Operating Revenue		
24	Contributions	8,477	24
25	Interest and Other Investment Income***	117,108	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 125,585	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Rental & Farm	197,694	28
28a	Gain on Disposal of Equipment	1,500	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 199,194	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,697,994	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	753,988	31
32	Health Care	1,057,177	32
33	General Administration	555,544	33
	B. Capital Expense		
34	Ownership	210,071	34
	C. Ancillary Expense		
35	Special Cost Centers	17,821	35
36	Provider Participation Fee	54,203	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,648,804	40
41	**Income before Income Taxes (line 30 minus line 40)****	49,190	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 49,190	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** Yes **If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing	1,763	1,979	50,489	25.51	2
3	Registered Nurses					3
4	Licensed Practical Nurses	7,544	8,206	163,966	19.98	4
5	Nurse Aides & Orderlies	12,388	13,580	200,624	14.77	5
6	Nurse Aide Trainees	44,741	48,221	445,385	9.24	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,664	1,864	17,871	9.59	9
10	Activity Assistants	1,749	1,966	21,619	11.00	10
11	Social Service Workers	3,836	4,308	39,437	9.15	11
12	Dietician	1,757	1,901	18,515	9.74	12
13	Food Service Supervisor					13
14	Head Cook	1,750	1,966	35,569	18.09	14
15	Cook Helpers/Assistants	1,491	1,667	18,540	11.12	15
16	Dishwashers	20,482	22,226	196,668	8.85	16
17	Maintenance Workers					17
18	Housekeepers	4,159	4,311	62,709	14.55	18
19	Laundry	5,948	6,484	61,210	9.44	19
20	Administrator	2,816	3,032	27,834	9.18	20
21	Assistant Administrator	2,496	2,496	60,000	24.04	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	5,034	5,642	68,109	12.07	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,288	2,528	23,290	9.21	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	121,906	132,377	$ 1,511,835 *	$ 11.42	34

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	130	$ 6,090	Ln 1,Col 3	35
36	Medical Director	36	4,100	Ln 9,Col 3	36
37	Medical Records Consultant				37
38	Nurse Consultant	8	95	Ln10, Col 3	38
39	Pharmacist Consultant	36	600	Ln10, Col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,703	Ln11, Col 3	44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	254	$ 13,588		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Brother Damien	Administrator	0	$ 75,000
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 75,000

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
Bacon Smith Koelling & Ohm	Accounting & Audit	$ 14,950
Premier Data	Payroll Service	2,296
American Appraisal	Asset Recordkeeping	1,410
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 18,656

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 28,096
Unemployment Compensation Insurance	
FICA Taxes	109,771
Employee Health Insurance	158,739
Employee Meals	21,080
Illinois Municipal Retirement Fund (IMRF)*	
Pension	35,616
TOTAL (agree to Schedule V, line 22, col.8)	$ 353,302

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 8)	96
Life Services Network	3,607
Catholic Health Assoc & Memberships	405
Division of Aging	50
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,158

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Travel	13
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 13

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 Report Period Beginning: 1/1/2002 Ending: 12/31/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arthur Merkle-Clara Knipprath Nursing Home # 0021832 **Report Period Beginning:** 1/1/2002 **Ending:** 12/31/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **$3,607 - Life Services Network**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **12.32**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **27,563** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,203**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **21,080** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **6,113**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **69**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **Smith Koelling Dykstra & Ohm, PC** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Arthur Merkle-Clara Knipprath Nursing Home
ID# 0021832
Report Period Beginning 1/1/02 Ending 12/31/02
Attachment to Schedule XX, Item 14

The portion of the building which is used for Independent Living Units is a completely separate section of the building with its own meters for utilities. Expenses, including depreciation, which relate to the Independent Living Units, are maintained separately in the accounting records.

12/31/2002

STATE OF ILLINOIS

Facility Name & ID Number: Arthur Merkle-Clara Knipprath Nursing Home 0021832

Diagnostic Report

				DIFFERENCE
Salary/Wages	Page 4, Line 45, Col 1		1,511,835	
	Page 20, Line 34, Col 3		1,511,835	0
Book Depreciation	Page 4, Line 30, Col 4		210,071	
Care Related Depr	Page 13, Line 82	120,849		
Non-Care Depr	PAGE 13, LINE 91, COL 3	89,222	210,071	0
Adjusted Depr	PAGE 4, LINE 30, COL 8		129,778	
	PAGE 13, LINE 83		129,718	(60)
Interest	PAGE 4, LINE 32, COL 3	0		
	PAGE 9, LINE 15, COL 10	0		0
Adjustments	PAGE 4, LINE 45, COL 7		(201,417)	
	PAGE 5, LINE 30, COL 1		(201,417)	0
Administrative Salaries	PAGE 3, LINE 17, COL 4		75,000	
				0
	PAGE 21, SCHED A		75,000	
PROFESSIONAL SERVICES	PAGE 3, LINE 19, COL 4		18,656	
	PAGE 21, SCHED C		18,656	0
DUES & SUBCRIPTIONS	PAGE 3, LINE 20, COL 8		4,158	
	PAGE 21, SCHED F		4,158	0
EMPLOYEE BENEFITS	PAGE 3, LINE 22, COL 8		353,302	
	PAGE 21, SCHED D		353,302	0
TRAVEL & SEMINAR	PAGE 3, LINE 24, COL 8		13	
	PAGE 21, SCHED G		13	0
DEPRECIATION-COST	PAGE 13, SCHED E, LINE 81		3,609,915	
	PAGE 11, SCHED A, LINE 3	57,000		
	PAGE 12, LINE 34, COL 4	3,012,095		
	PAGE 13, LINE 75, COL 1	453,876		
	PAGE 13, LINE 80, COL 4	86,944	3,609,915	0
DEPREC - CURRENT BK	PAGE 13, SCHED E, LINE 82		120,849	
	PAGE 12, LINE 34, COL 5	92,190		
	PAGE 13, LINE 75, COL 2	23,808		
	PAGE 13, LINE 80, COL 5	4,851	120,849	0
DEPREC - STRAIGHT LINE	PAGE 13, SCHED E, LINE 83		129,718	
	PAGE 12, LINE 34, COL 7	101,059		
	PAGE 13, LINE 75, COL 3	23,808		
	PAGE 13, LINE 80, COL 6	4,851	129,718	0
DEPREC - ADJUSTMENTS	PAGE 13, SCHED E, LINE 84		8,869	
	PAGE 12, LINE 34, COL 8	8,869		
	PAGE 13, LINE 75, COL 4	0		
	PAGE 13, LINE 80, COL 7	0	8,869	0
ACCUMULATED DEPR	PAGE 13, SCHED E, LINE 85		2,326,602	
	PAGE 12, LINE 34, COL 9	1,992,481		
	PAGE 13, LINE 75, COL 6	274,051		
	PAGE 13, LINE 80, COL 9	60,070	2,326,602	0
BALANCE SHEET	TOTAL ASSETS-PAGE 17, LINE 25		6,294,687	
	TOTAL LIAB-PAGE 17, LINE 48		6,294,687	0
EQUITY	TOTAL EQUITY, PAGE 17, LINE 47		6,138,667	
	ENDING EQUITY, PAGE 18, LINE 24		6,138,667	0